STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155135	A. BUILDING 01 B. WING	12/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW NURSING AND REHABILITATION CENTER	1510 CLINIC DR BEDFORD, IN47421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 12/20/11 Facility Number: 000060 Provider Number: 155135 AIM Number: 100266600 Surveyor: Phillip Komsiski, Life Safety Code Specialist At this Life Safety Code survey, Westview Nursing and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction with a basement was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. Fifteen	K0000	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a post survey review on or after 1/6/12.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	resident rooms on Cottage hall were provided with smoke detectors. The facility has a capacity of 149 and had a census of 75 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/29/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0017 SS=E	Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 Based on observation and interview, the facility failed to ensure 1 of 1 open use areas was separated from the corridor, or met an Exception. LSC 19.3.6.1, Exception # 1 Spaces shall be permitted to be unlimited in area and open to the	K0017	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests**	01/06/2012

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	corridor, provided that the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. This deficient practice could affect any resident using the Service corridor which is adjacent to the Employee Breakroom to access an exit as well as visitors and staff. Findings include: Based on observation on 12/20/11 at 2:44 p.m. with the Maintenance Supervisor, the Employee Breakroom on Service hall north was open to the corridor. Exception # 1, requirement (c) of the Life Safety Code, Chapter 19.3.6.1 was not met as follows: the open area was not protected by an automatic smoke detection system		**that the 2567 Plan of Correction be considered the letter of credible allegation and requests a post survey review on or after 1/6/12.** **K-017 Break Room Smoke Detector** **Facility failed to ensure 1 of 1 open use areas for employees was properly protected by an automatic smoke detection system.** **What corrective actions will be accomplished for these residents found to have been affected by the deficient practice?** No residents were specifically affected by this finding. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No residents were specifically affected by this finding. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** An automatic smoke detection	

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	or arranged to allow direct supervision by facility staff from a continuously staffed area such as a nurses' station. Based on interview on 12/20/11 at 2:47 p.m. with the Maintenance Supervisor, it was acknowledged the Employee Breakroom on Service hall north was open to the corridor without supervision from the nurse's station and was not protected by automatic smoke detection. 3.1-19(b)		device has been installed in this area. Maintenance Supervisor/Designee will be responsible to ensure compliance through scheduled rounds. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Maintenance Supervisor/Designee will be responsible to ensure compliance through scheduled rounds each thirty days for a period of ninety days. These rounds will be reviewed by the facility Quality Assurance Program for potential action or follow-up. **This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of completion is: 1/6/12**	

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K0018 SS=E	Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 1 corridor doors entering Dietary hall would latch into their frames. This deficient practice could affect 8 residents in the Main dining room next to Dietary hall as well as visitors and staff. Findings include: Based on observation on 12/20/11 during the tour at 1:20 p.m. with the Maintenance Supervisor, the door entering Dietary hall did not have a latching device on the door and therefore could not latch into its frame. Based on interview on 12/20/11 at 1:22 p.m. with the Maintenance Supervisor, it was acknowledged the door separating the Dietary hall from the Main dining room would not latch into its frame.	K0018	**K-018 Corridor door entering Dietary service area should be latched into frame.** **Facility failed to ensure 1 of 1 corridor door entering Dietary hall would latch into its frame.** **What corrective actions will be accomplished for these residents found to have been affected by the deficient practice?** Proper latching mechanism has been installed causing Dietary service door to be latched when closed. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** Any residents in the main dining room will be positively affected	01/06/2012

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	3.1-19(b)		now that the proper latching mechanism has been installed causing Dietary service door to be latched when closed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Proper latching mechanism has been installed causing Dietary service door to be latched when closed. Maintenance Supervisor/Designee will be responsible to ensure compliance through scheduled rounds. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Maintenance Supervisor/Designee will be responsible to ensure compliance through scheduled rounds each thirty days for a period of ninety days. These rounds will be reviewed by the facility Quality Assurance Program for potential action or follow-up. **This Plan of Correction constitutes our credible allegation of compliance with**	

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			all regulatory requirements. Our date of completion is: 1/6/12	
K0027 SS=E	Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observations and interview, the facility failed to ensure 1 of 10 sets of smoke barrier doors were equipped with the appropriate hardware to allow the door which must close first, to always close first so both doors will always close completely as a pair. Centers for Medicare & Medicaid Services (CMS) requires sets of smoke barrier doors that swing in the same direction and equipped with an astragal to have a coordinator to ensure the door which must close first always closes first. This deficient practice could affect 30 residents on Moving Forward and 24 residents on Rehabilitation Therapy west including staff and visitors. Findings include: Based on observation on 12/20/11 during the tour between 12:30 p.m. and 12:55	K0027	**K-027 Smoke barrier doors lacked a closure coordinator** **Facility failed to ensure 1 of 10 corridor doors were equipped with a closure coordinator to ensure the door with the metal astragal always closed first.** **What corrective actions will be accomplished for these residents found to have been affected by the deficient practice?** Coordinators have been installed on this single set of smoke barrier doors. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** Coordinators have been installed on this single set of smoke barrier doors. As noted on the 2567,	01/06/2012

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	155135	A. BUILDING 01 B. WING	12/20/2011

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	p.m. with the Maintenance Supervisor, the set of smoke barrier doors leading into Rehabilitation Therapy west hall, which swung in the same direction and were equipped with a metal astragal, lacked a coordinator to allow the astragal side of the door to close first. When tested these sets of smoke doors closed properly with the astragal door closing first. Based on interview on 12/20/11 at 12:33 p.m. with the Maintenance Supervisor, it was acknowledged the aforementioned smoke barrier doors lacked a coordinator to ensure the door with the metal astragal always closed first. 3.1-19(b)		"When tested these sets of smoke doors closed properly with the astragal door closing first." As such, no other residents were affected by the lack of coordinators on these doors. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Maintenance Supervisor/Designee will be responsible to ensure compliance through scheduled rounds. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Maintenance Supervisor/Designee will be responsible to ensure compliance through scheduled rounds each thirty days for a period of ninety days. These rounds will be reviewed by the facility Quality Assurance Program for potential action or follow-up. **This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of completion is:**	

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K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1		**1/6/12**	
	Based on observation and interview, the facility failed to ensure 1 of 3 doors leading to hazardous areas such as rooms with combustible items were provided with self closing devices which would cause the door to automatically close and latch into the door frame. This deficient practice affects 8 residents observed in the Activities room which is next to the Service corridor as well as visitors and staff. Findings include: Based on observation on 12/20/11 at 1:45 p.m. with the Maintenance Supervisor, the corridor door to the Housekeeping room on Service hall which was larger than 50 square feet in size, next to the Activities room, had twenty five cardboard boxes without a self closing device on the corridor door. Based on interview on 12/20/11 at 1:28 p.m. with the	K0029	**K-029 Door closure required for housekeeping storage room** **Facility failed to ensure 1 of 3 storage room doors were equipped with a proper door closure.** **What corrective actions will be accomplished for these residents found to have been affected by the deficient practice?** The proper door closure has been installed on the door of this storage room. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** The proper door closure has been installed on the door of this storage room. There are no residents using the employee service hall, thus no other	01/06/2012

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	155135	A. BUILDING 01 B. WING	12/20/2011

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	Maintenance Supervisor, it was acknowledged the aforementioned door leading into the Housekeeping room was not equipped with a self closing device on the door. 3.1-19(b)		residents were affected by the lack of this door closure. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Maintenance Supervisor/Designee will be responsible to ensure compliance and proper function through scheduled rounds. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Maintenance Supervisor/Designee will be responsible to ensure compliance and proper function through scheduled rounds each thirty days for a period of ninety days. These rounds will be reviewed by the facility Quality Assurance Program for potential action or follow-up. **This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of completion is: 1/6/12**	

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	155135	A. BUILDING 01 B. WING	12/20/2011

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K0048 SS=E	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to include the use of kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility in the event of an emergency. LSC 19.2.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice affects any resident, as well as staff and visitors in the vicinity of the kitchen. Findings include: Based on a review of the facility's written fire disaster plan on 12/20/11 at 4:45 p.m. with the Maintenance Supervisor the fire disaster plan did not include the use of ABC or the K class fire extinguishers located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on an	K0048	**K-048 The use of fire extinguishers in relationship with the use of the kitchen overhead extinguishing system.** **Facility failed to include the use of kitchen fire extinguishers in 1 of 1 written plans for the facility in the case of an emergency.** **What corrective actions will be accomplished for these residents found to have been affected by the deficient practice?** The emergency plan now includes a written description of the use of kitchen fire extinguishers in conjunction with the overhead fire extinguisher system. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** Other Residents were identified as any resident in the vicinity of the kitchen. The emergency plan now includes a written description of the use of kitchen fire extinguishers in conjunction with the overhead fire extinguisher system.	01/06/2012

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	interview on 12/20/11 at 4:50 p.m. with the Maintenance Supervisor it was acknowledged the written fire safety plan for the facility did not include mention of the ABC or K class fire extinguishers. 3.1-19(b		**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Maintenance Supervisor/Designee will be responsible to ensure compliance through scheduled rounds. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Maintenance Supervisor/Designee will be responsible to ensure compliance through scheduled rounds each thirty days for a period of ninety days. These rounds will be reviewed by the facility Quality Assurance Program for potential action or follow-up. **This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of completion is: 1/6/12**	
K0070 SS=E	Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8			

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	Based on observation and interview, the facility failed to provide documentation for the use of 1 of 1 portable heating units used in nonsleeping staff areas. This deficient practice could affect 5 residents observed standing in the hall next the the Business Manager's office on Main front hall as well as visitors and staff. Findings include: Based on observation on 12/20/11 at 1:15 p.m. with the Maintenance Supervisor, the business office next to the Administrative office on Main hall front contained one portable space heater which was not operating at the time, but documentation was not available to verify the heating elements did not exceed two hundred and twelve degrees F. Based on interview on 12/20/11 at 11:17 p.m. with the Maintenance Supervisor, it was acknowledged the information for the portable heating unit, though not in use, was not available for review to verify the portable heating units did not exceed two hundred and twelve degrees F, and the facility did not have a portable heating unit policy. 3.1-19(b)	K0070	**K-070 Portable space heaters in staff areas** **Facility failed to provide documentation for the use of 1 of 1 portable heating units used in a non-sleeping staff area.** **What corrective actions will be accomplished for these residents found to have been affected by the deficient practice?** The portable heating unit has been removed from the facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** Other Residents were identified as any resident in the vicinity of the business office. The portable heating unit has been removed from the facility. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Maintenance Supervisor/Designee will be responsible to ensure compliance through scheduled rounds. Staff has been educated that no portable heating units are	01/06/2012

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	155135	A. BUILDING 01 B. WING	12/20/2011

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			permissible in the facility. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Maintenance Supervisor/Designee will be responsible to ensure compliance through scheduled rounds each thirty days for a period of ninety days. These rounds will be reviewed by the facility Quality Assurance Program for potential action or follow-up. **This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of completion is: 1/6/12**	

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	155135	A. BUILDING 01 B. WING	12/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW NURSING AND REHABILITATION CENTER	1510 CLINIC DR BEDFORD, IN47421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0074 SS=E	Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 Based on observation, record review and interview; the facility failed to provide flame resistant documentation for window curtains in 2 of 4 resident rooms on Northeast hall. This deficient practice could affect 8 residents as well as visitors and staff. Findings include: Based on observations on 12/20/11 from 2:10 p.m. to 2:20 p.m. with the Maintenance Supervisor, the window curtains installed in resident rooms 34 and 37 lacked attached documentation confirming they were inherently flame retardant. Based on interview on 12/20/11 concurrent with the observations with the Maintenance Supervisor, it was	K0074	**K-074 Non-flame resistant curtains hanging in resident rooms** **Facility failed to provide flame resistant documentation for window curtains in 2 of 4 resident rooms** **What corrective actions will be accomplished for these residents found to have been affected by the deficient practice?** Curtains lacking fire resistant documentation have been removed from the facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**	01/06/2012

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	acknowledged there was no documentation regarding flame retardancy for these window curtains and the curtains were not provided by the facility. 3.1-19(b)		Other Residents were identified as any resident in the vicinity of the business office. The portable heating unit has been removed from the facility. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Maintenance Supervisor/Designee will be responsible to ensure compliance through scheduled rounds. Staff has been educated that portable heating units are not permissible in the facility. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Maintenance Supervisor/Designee will be responsible to ensure compliance through scheduled rounds each thirty days for a period of ninety days. These rounds will be reviewed by the facility Quality Assurance Program for potential action or follow-up. **This Plan of Correction constitutes our credible allegation of compliance with**	

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			all regulatory requirements. Our date of completion is: 1/6/12	
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to document the alternate source of power from the generator was capable of automatically connecting to load within 10 seconds for the last 12 of 12 months. NFPA 99, the Standard for Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. NFPA 99, 3-6.3.1.2 requires the emergency system to be arranged so, in the event of failure of the normal power source, the alternate source of power will automatically connect to load within 10 seconds. This deficient practice could affect all occupants in the facility as well as visitors and staff if it could not be assured all residents were safeguarded by the facility with a generator which would operate under load conditions when needed during a power failure. Findings include: Based on review of Generator Log records on 12/20/11 at 3:30 p.m. with the Maintenance supervisor, the number of	K0144	**K-144 Failure to document generator connecting within 10 seconds.** **Facility failed to document the alternate source of power from the generator was capable of automatically connecting to load within 10 seconds.** **What corrective actions will be accomplished for these residents found to have been affected by the deficient practice?** All residents could be affected by this issue. The regular testing that had been completed during this time period will now be documented to ensure a record of proof that the generator is connecting to load within 10 seconds. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents could be affected by this issue. The regular testing that had been completed during this time period will now be	01/06/2012

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	seconds for the generator to transfer load was not documented. Based on interview on 12/20/11 at 3:33 p.m. with the Maintenance Supervisor, it was acknowledged the information on time of load transfer had not been recorded for the past twelve months and it was unknown how many seconds were required to transfer load. 3.1-19(b)		documented to ensure a record of proof that the generator is connecting to load within 10 seconds. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Maintenance Supervisor/Designee will be responsible to ensure compliance through scheduled testing of the generator. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Maintenance Supervisor/Designee will be responsible to ensure compliance through scheduled testing documentation each thirty days for a period of ninety days. This testing documentation will be reviewed by the facility Quality Assurance Program for potential action or follow-up. **This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of completion is:**	

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K0154 SS=C	Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 Based on record review and interview, the facility failed to protect 75 of 75 residents by providing a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for more than 4 hours in a 24 hour period in accordance with LSC, Section 9.7.6.1. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection Systems. NFPA 25, 11-2 requires an appointed sprinkler impairment coordinator. NFPA 25, 11-5 requires a preplanned program to include evacuation or an approved fire watch and 11-5(d) requires the local fire department be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified and 11-5(f) requires notification of supervisors in the area in addition to those already mentioned and lastly 11-7 requires notification of	K0154	**1/6/12** **K-154 Notifying all entities after sprinkler system has been restored** **Facility failed to provide documentation that all appropriate entities would be notified when the sprinkler system had been restored, if it had experienced a failure.** **What corrective actions will be accomplished for these residents found to have been affected by the deficient practice?** All residents could be affected. The plan now includes instruction to notify listed, appropriate entities following the restoring of the sprinkler system should it experience a failure. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents could be affected. The plan now includes instruction to notify listed, appropriate entities following the restoring of	01/06/2012

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	everyone again when the system is restored. This deficient practice could affect all residents, staff and visitors. Findings include: Based on Sprinkler record review on 12/20/11 at 4:05 p.m. with the Maintenance Supervisor, the facility did have a written policy and procedure for an impaired sprinkler system available for review, but it did not address notifying all entities again once the sprinkler system has been restored to normal. Based on interview on 12/20/11 at 4:06 p.m. with the Maintenance Supervisor, it was acknowledged the fire watch policy did not include notifying all entities again once the sprinkler system had been restored to normal operation. 3.1-19(b)		the sprinkler system should it experience a failure. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Maintenance Supervisor/Designee will be responsible to ensure compliance through following the item added to the plan to make notification following the restoring of the sprinkler system, should it ever fail. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Maintenance Supervisor/Designee will be responsible to ensure compliance through ongoing, scheduled rounds and review of emergency plans. These rounds will be reviewed by the facility Quality Assurance Program for potential action or follow-up. **This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of completion is:**	

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